MEDICAL RECORD	REPORT OF MEDICAL EXAMINATION	DATE OF EXAM

(1) LAST NAME - FIRST NAME - MIDDLE NAME | (2) IDENTIFICATION NUMBER | (3) GRADE AND COMPONENT OR POSITION

(4) HOME ADDRESS *(Number, street or RFD, city or town, state and ZIP Code)* | (5) EMERGENCY CONTACT *(Name and address of contact)*

(6) DATE OF BIRTH | (7) AGE | (8) SEX ☐ FEMALE ☐ MALE | (9) RELATIONSHIP OF CONTACT

(10) PLACE OF BIRTH | (11) RACE ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ HISPANIC WHITE ☐ HISPANIC BLACK ☐ ASIAN/PACIFIC ISLANDER

(12a) AGENCY | (12b) ORGANIZATION UNIT | (13) TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY | b. CIVILIAN

(14) NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS | (15) RATING OR SPECIALTY OF EXAMINER

(16) PURPOSE OF EXAMINATION

ALL (17) CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL	NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE *(Over 40 or clinically indicated)*	
	B. EARS - GENERAL *(INTERNAL CANALS)* *(Auditory acuity under items 39 and 40)*			P. TESTICULAR	
				Q. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Hemocult Results)*	
	C. DRUMS *(Perforation)*			R. ENDOCRINE SYSTEM	
	D. NOSE			S. G-U SYSTEM	
	E. SINUSES			T. UPPER EXTREMITIES *(Strength, range of motion)*	
	F. MOUTH AND THROAT			U. FEET	
	G. EYES - GENERAL *(Visual acuity and refraction under items 28, 29, and 36)*			V. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
	H. OPTHALMOSCOPIC			W. SPINE, OTHER MUSCULOSKELETAL	
	I. PUPILS *(Equality and reaction)*			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	J. OCULAR MOTILITY *(Associated parallel movements nystagmus)*			Y. SKIN, LYMPHATICS	
	K. LUNGS AND CHEST			Z. NEUROLOGIC *(Equilibrium tests under item 41)*	
				AA. PSYCHIATRIC *(Specify any personality deviation)*	
				BB. BREASTS	
	N. ABDOMEN AND VISCERA *(Include hernia)*			CC. PELVIC *(Females only)*	

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary.)*

C. VALSALVA

(18) DENTAL *(Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)*

0 (1 2 3 / 32 31 30 / 0) Restorable Teeth; / (1 2 3 / 32 31 30 /) Non-restorable Teeth; X (1 2 3 / 32 31 30 / X) Missing Teeth; X X X (1 2 3 / 32 31 30 / X X X) Replaced by Dentures; (X) (1 2 3 / 32 31 30 / (X)) Fixed Partial Dentures

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

TYPE II
CLASS I

(19) TEST RESULTS (Copies of results are preferred as attachments)

(A) URINALYSIS: (1) SPECIFIC GRAVITY | (B) CHEST X-RAY OR PPD *(Place, date, film number and result)*

(2) URINE ALBUMIN | (4) MICROSCOPIC

(3) URINE SUGAR

C. SYPHILIS SEROLOGY *(Specify test used and results)* | (D) EKG: 2 copies ALL | (E) BLOOD TYPE AND RH FACTOR | (F) OTHER TESTS: HCT: HGB: HGB-S: HDL: TRIG: HIV: G6PD: CHOL: DNA: UDS: